FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041186

Facility Name: Tri-State Nursing & Rehab Ctr

Address: 2500 East 175th Street (Number) Lansing (City) 60438 (Zip Code)

County: Cook

Telephone Number: (708) 474-7330 **Fax #** (708) 474-7391

HFS ID Number: 364034144001

Date of Initial License for Current Owners: 09/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,967	6	3,467	20,440	8
9	SNF/PED					9
10	ICF	3,371	3,639		7,010	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,338	3,645	3,467	27,450	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.53%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 2,942

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,835	30,058	11,961	224,854		224,854	(1,303)	223,551			1
2	Food Purchase		115,009		115,009	(4,818)	110,191	1,932	112,123			2
3	Housekeeping	104,122	27,520		131,642		131,642	(2,617)	129,025			3
4	Laundry	76,726	11,155		87,881		87,881		87,881			4
5	Heat and Other Utilities			100,558	100,558		100,558	1,085	101,643			5
6	Maintenance	39,489	40	84,553	124,082		124,082	1,599	125,681			6
7	Other (specify):*							2,185	2,185			7
8	**TOTAL General Services**	403,172	183,782	197,072	784,026	(4,818)	779,208	2,880	782,088			8
	B. Health Care and Programs											
9	Medical Director			13,320	13,320		13,320		13,320			9
10	Nursing and Medical Records	1,306,421	25,649	27,862	1,359,932		1,359,932	(2,136)	1,357,796			10
10a	Therapy	105,324		1,547	106,871		106,871	259	107,130			10a
11	Activities	92,379	6,585	3,519	102,483		102,483		102,483			11
12	Social Services	66,733		828	67,561		67,561		67,561			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							973	973			15
16	**TOTAL Health Care and Programs**	1,570,857	32,234	47,076	1,650,167		1,650,167	(904)	1,649,263			16
	C. General Administration											
17	Administrative	81,177			81,177		81,177	20,910	102,087			17
18	Directors Fees											18
19	Professional Services			186,061	186,061		186,061	(108,698)	77,363			19
20	Dues, Fees, Subscriptions & Promotions			34,362	34,362		34,362	(11,045)	23,317			20
21	Clerical & General Office Expenses	59,935	11,647	209,128	280,710		280,710	(75,813)	204,897			21
22	Employee Benefits & Payroll Taxes			339,335	339,335	4,818	344,153	(5,801)	338,352			22
23	Inservice Training & Education			45	45		45		45			23
24	Travel and Seminar			537	537		537	2,431	2,968			24
25	Other Admin. Staff Transportation			439	439		439		439			25
26	Insurance-Prop.Liab.Malpractice			79,647	79,647		79,647	958	80,605			26
27	Other (specify):*							17,771	17,771			27
28	**TOTAL General Administration**	141,112	11,647	849,554	1,002,313	4,818	1,007,131	(159,286)	847,845			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,115,141	227,663	1,093,702	3,436,506		3,436,506	(157,311)	3,279,195			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr #0041186 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			52,437	52,437		52,437	160,726	213,163			30
31	Amortization of Pre-Op. & Org.							7,803	7,803			31
32	Interest			32	32		32	48,396	48,428			32
33	Real Estate Taxes			177,166	177,166		177,166	892	178,058			33
34	Rent-Facility & Grounds			337,260	337,260		337,260	(333,034)	4,226			34
35	Rent-Equipment & Vehicles			2,366	2,366		2,366	776	3,142			35
36	Other (specify):*											36
37	**TOTAL Ownership**			569,261	569,261		569,261	(114,441)	454,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		199,220	188,428	387,648		387,648	(12,963)	374,685			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		199,220	234,418	433,638		433,638	(12,963)	420,675			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,115,141	426,883	1,897,381	4,439,405		4,439,405	(284,714)	4,154,691			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	71,675	30		9
10	Interest and Other Investment Income	(59,475)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(567)	21		18
19	Entertainment				19
20	Contributions	(800)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(109,804)	21		24
25	Fund Raising, Advertising and Promotional	(11,973)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(95)	20		28
29	Other-Attach Schedule	(136,856)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (248,045)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(36,669)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (36,669)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (284,714)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Tri-State Nursing & Rehab Ctr

ID# 0041186

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (159)	21	1
2	Jury Duty Income	(180)	10	2
3	Theft Loss	(70)	21	3
4	Collection Expense	(297)	21	4
5	Cope Dues	(306)	20	5
6	Prior Year Legal	(298)	19	6
7	Non-Allowable Billing Consulting	(6,909)	19	7
8	Capitalized R & M	(3,474)	06	8
9	Assisted Living Parcel Real Estate Tax	(2,873)	33	9
10	Non-Allowable Expense	(48,000)	21	10
11	Bldg.Co.- State Replacement Tax	(1,339)	21	11
12	Bldg. Expenses of SLF	(29,056)	21	12
13	Bldg. Co. - Land Trust Fees	(150)	21	13
14	Bldg. Co. - Fairfax Interest Exp	(43,753)	32	14
15				15
16				16
17				17
18				18
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20				20
21				21
22				22
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100				100
101	**Total**	(136,856)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					172		(1,099)	(376)				(1,303)	1
2	Food Purchase	(150)			(52)				2,134				1,932	2
3	Housekeeping				(2,617)								(2,617)	3
4	Laundry													4
5	Heat and Other Utilities					1,085							1,085	5
6	Maintenance	(3,474)				2,652		2,392	29				1,599	6
7	Other (specify):*						1,124	626	435				2,185	7
8	**TOTAL General Services**	(3,624)			(2,670)	3,909	1,124	1,919	2,222				2,880	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(180)			(1,956)								(2,136)	10
10a	Therapy							259					259	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						938	35					973	15
16	**TOTAL Health Care and Programs**	(180)			(1,956)		938	294					(904)	16
	C. General Administration													
17	Administrative					1,778	4,566	14,356	210				20,910	17
18	Directors Fees													18
19	Professional Services	(7,199)				(101,504)			5				(108,698)	19
20	Fees, Subscriptions & Promotions	(13,174)			(209)	2,332			6				(11,045)	20
21	Clerical & General Office Expenses	(189,442)	30,545			8,669	(4,566)	78,498	483				(75,813)	21
22	Employee Benefits & Payroll Taxes				(7)		(5,794)						(5,801)	22
23	Inservice Training & Education													23
24	Travel and Seminar					2,264			167				2,431	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					809			149				958	26
27	Other (specify):*						4,449	13,322					17,771	27
28	**TOTAL General Administration**	(209,815)	30,545		(215)	(85,652)	(1,345)	106,176	1,020				(159,286)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(213,619)	30,545		(4,841)	(81,743)	717	108,389	3,242				(157,311)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Tri-State Nursing & Rehab Ctr **#** 0041186 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	71,675	76,346			11,304			80	1,321			160,726	30
31	Amortization of Pre-Op. & Org.		7,803										7,803	31
32	Interest	(103,228)	149,001			1,887			269	467			48,396	32
33	Real Estate Taxes	(2,873)	2,873			892							892	33
34	Rent-Facility & Grounds		(337,260)			4,226							(333,034)	34
35	Rent-Equipment & Vehicles					761			15				776	35
36	Other (specify):*													36
37	TOTAL Ownership	(34,426)	(101,237)			19,070			364	1,788			(114,441)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(3,074)				(5,919)	(3,970)			(12,963)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				(3,074)				(5,919)	(3,970)			(12,963)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(248,045)	(70,692)		(7,915)	(62,673)	717	108,389	(2,313)	(2,182)			(284,714)	45

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lansing Healthcare Properties		Bldg. Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 337,260	Lansing Healthcare Properties	100.00%	$	$ (337,260)	1
2	V	21	Land Trust Fees		Lansing Healthcare Properties	100.00%	150	150	2
3	V	21	Expenses re SLF		Lansing Healthcare Properties	100.00%	29,056	29,056	3
4	V	21	State Replacement Tax		Lansing Healthcare Properties	100.00%	1,339	1,339	4
5	V	30	Depreciation		Lansing Healthcare Properties	100.00%	76,346	76,346	5
6	V	31	Amortization		Lansing Healthcare Properties	100.00%	7,803	7,803	6
7	V	33	RE Tax Expenses Asst Living		Lansing Healthcare Properties	100.00%	2,873	2,873	7
8	V	32	Interest - Fairfax		Lansing Healthcare Properties	100.00%	43,753	43,753	8
9	V	32	Interest - Cole Taylor		Lansing Healthcare Properties	100.00%	105,248	105,248	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 337,260			$ 266,568	$ * (70,692)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 63,346	$ 63,346	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	63,346	CCS EMPLOYEE BENEFIT GROUP	100.00%		(63,346)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,346			$ 63,346	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD	527	XCEL MEDICAL SUPPLY, LLC	100.00%	474	(52)	16
17	V	03	HOUSEKEEPING	26,400	XCEL MEDICAL SUPPLY, LLC	100.00%	23,783	(2,617)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10	NURSING	19,732	XCEL MEDICAL SUPPLY, LLC	100.00%	17,776	(1,956)	20
21	V	11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM	2,105	XCEL MEDICAL SUPPLY, LLC	100.00%	1,896	(209)	22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	69	XCEL MEDICAL SUPPLY, LLC	100.00%	62	(7)	24
25	V	39	ANCILLARY	31,004	XCEL MEDICAL SUPPLY, LLC	100.00%	27,930	(3,074)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,836			$ 71,921	$ * (7,915)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 172	$ 172	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,085	1,085	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	2,652	2,652	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	1,778	1,778	19
20	V	19	Professional Fees	111,462	Care Centers, Inc.	100.00%	9,958	(101,504)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	2,332	2,332	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	8,669	8,669	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,264	2,264	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	809	809	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	11,304	11,304	25
26	V	32	Interest		Care Centers, Inc.	100.00%	1,887	1,887	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	892	892	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,226	4,226	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	761	761	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 111,462			$ 48,789	$ * (62,673)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 7,451	Care Centers, Inc.	100.00%	$ 7,451	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,124	1,124	16
17	V	10	Nursing Salary	5,124	Care Centers, Inc.	100.00%	5,124		17
18	V	10a	Rehab Salary	1,235	Care Centers, Inc.	100.00%	1,235		18
19	V								19
20	V								20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	938	938	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%	4,566	4,566	22
23	V	21	Office Salary	25,173	Care Centers, Inc.	100.00%	20,607	(4,566)	23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	4,449	4,449	24
25	V	22	Employee Benefits	5,794	Care Centers, Inc.	100.00%		(5,794)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,777			$ 45,494	$ * 717	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		01	Dietary Salary	$ 3,066	Care Centers, Inc.	100.00%	$ 1,967	$ (1,099)	15
16	V									16
17	V		06	Maintenance Salary		Care Centers, Inc.	100.00%	2,392	2,392	17
18	V		07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	626	626	18
19	V									19
20	V		10a	Rehab Salary		Care Centers, Inc.	100.00%	259	259	20
21	V		15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	35	35	21
22	V									22
23	V		17	Administration Salary		Care Centers, Inc.	100.00%	14,356	14,356	23
24	V		21	Office Salary		Care Centers, Inc.	100.00%	78,498	78,498	24
25	V		27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	13,322	13,322	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 3,066			$ 111,455	$ * 108,389	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 4,057	Care Centers, Inc. - Health Systems Division	100.00%	$ 820	$ (3,237)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	2,134	2,134	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	29	29	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	210	210	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	5	5	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	6	6	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	483	483	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	167	167	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	149	149	23
24	V	30	Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	80	80	24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	269	269	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	15	15	26
27	V	39	Ancillary Enteral Supplies	12,489	Care Centers, Inc. - Health Systems Division	100.00%	6,570	(5,919)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,861	2,861	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	435	435	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,546			$ 14,233	$ * (2,313)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 1,321	$ 1,321	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	467	467	16
17	V	39	Vent Reimbursement	3,970	Vent Lease, LLC.	100.00%		(3,970)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,970			$ 1,788	$ * (2,182)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.19%	See Attached	0.58	1.25%	Alloc. Salary	$ 1,401	17-7	1
2	Adam Vales	Relative	Clerical	4.76%	See Attached	0.42	1.05%	Alloc. Salary	516	22-7	2
3	Kim Rudolph	Relative	Clerical		See Attached	0.41	1.17%	Alloc. Salary	595	22-7	3
4	Mark Steinberg	Relative	Administrative		See Attached	1.01	1.84%	Alloc. Salary	1,349	17-7	4
5	Gale Rothner	Relative	Administrative		See Attached	0.64	1.83%	Alloc. Salary	1,430	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,291		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 63,346	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 63,346	25

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation						474	2
3	03	HOUSEKEEPING	Direct Allocation						23,783	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						17,776	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						1,896	8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						62	10
11	39	ANCILLARY	Direct Allocation						27,930	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 71,921	25

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	27,450	$ 172	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		27,450	1,085	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		27,450	2,652	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		27,450	1,778	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		27,450	9,958	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		27,450	2,332	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		27,450	8,669	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		27,450	2,264	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		27,450	809	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		27,450	11,304	11
12	32	Interest	Patient Days	1,497,287	32	102,930		27,450	1,887	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		27,450	892	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		27,450	4,226	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		27,450	761	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 48,789	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			301,710	301,710		7,451	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			46,639			1,124	2
3	10	Nursing Salary	Direct Cost			425,833	425,833		5,124	3
4	10a	Rehab Salary	Direct Cost			55,464	55,464		1,235	4
5										5
6										6
7	15	Emp. Ben. - Healthcare	Direct Cost			67,757			938	7
8	17	Administration Salary	Direct Cost			5,566	5,566		4,566	8
9	21	Office Salary	Direct Cost			419,879	419,879		20,607	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			71,906			4,449	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,394,755	$ 1,208,453		$ 45,494	25

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	27,450	1,967	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	27,450	2,392	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		27,450	626	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	27,450	259	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		27,450	35	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	27,450	14,356	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	27,450	78,498	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		27,450	13,322	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 111,455	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		16,546	820	1
2	02	Food	Income			160,931			2,134	2
3	06	Maintenance	Billable Income	928,452		1,614		16,546	29	3
4	17	Administration	Billable Income	928,452		11,797		16,546	210	4
5	19	Professional Fees	Billable Income	928,452		262		16,546	5	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		16,546	6	6
7	21	Office & Clerical	Billable Income	928,452		27,087		16,546	483	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		16,546	167	8
9	26	Insurance	Billable Income	928,452		8,379		16,546	149	9
10	30	Depreciaton	Billable Income	928,452		4,499		16,546	80	10
11	32	Interest	Billable Income	928,452		15,077		16,546	269	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		16,546	15	12
13	39	Ancillary Enteral Supplies	Income			327,517			6,570	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	16,546	2,861	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		16,546	435	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 14,233	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	3,970	$ 1,321	1
2	32	Interest	Direct Billing	593,410	29	69,863		3,970	467	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 1,788	25

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cole Taylor Bank		X	Mortgage	$22,010.00	9/1/95	$ 2,620,000	$ 1,873,003			$ 105,248	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Corus Bank		X								32	6
7	Fairfax HC Properties	X						435,000			43,753	7
8	See Supplemental Schedule										(41,130)	8
9	TOTAL Facility Related				$22,010.00		$ 2,620,000	$ 2,308,003			$ 107,903	9
	B. Non-Facility Related*											
10	Interest Income										(59,475)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (59,475)	14
15	TOTALS (line 9+line14)						$ 2,620,000	$ 2,308,003			$ 48,428	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. From Care Centers		X				$	$			$ 2,156	8
9	Alloc. From Vent Lease		X								467	9
10	Fairfax HC Properties	X									(43,753)	10
11												11
12												12
13												13
14	TOTAL Working Capital										(41,130)	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 160,142	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 165,432	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,290	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 172,767	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 178,057	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	128,577	8
	2001	133,605	9
	2002	129,274	10
	2003	152,523	11
	2004	164,540	12

2005 Accrual = 2004 Tax $164,540 x 1.05 = $172,767

Care Centers Allocation $892.14

RE Tax Assisted Living Parcel $2,873.20 - adjusted out on page 5A

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-30-305-035-0000	Long Term Care Property	$ 164,540.45	$ 164,540.45
2.	30-30-304-018-0000	None-Care Property	$ 2,873.20	$
3.	See Attached	Home Office Allocation	$ 113,459.00	$ 892.14
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 280,872.65	$ 165,432.59

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tri-State Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041186

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,244 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 40,639
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 7,803
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 84,986	1
2	2201 Main LLC Allocation			6,448	2
3	TOTALS			$ 91,434	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	24,431		20	1,222	1,222	12,544	9
10	Various			1996	82,791		20	4,140	4,140	40,274	10
11	Various			1997	44,854		20	2,245	2,245	19,101	11
12	Various			1998	47,497		20	2,478	2,478	19,477	12
13	Various			1999	39,389		20	1,972	1,972	13,241	13
14	Various			2000	13,995		20	701	701	3,818	14
15	Various			2001	20,621		20	1,033	1,033	4,830	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,932,035	76,346		146,602	70,256	921,867	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		25,305	1,037		1,037		3,125	68
69	Financial Statement Depreciation			52,437			(52,437)		69
70	TOTAL (lines 4 thru 69)		$ 3,230,918	$ 129,820		$ 161,430	$ 31,610	$ 1,038,277	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,230,918	$ 129,820		$ 161,430	$ 31,610	$ 1,038,277	1
2	Paint	2002	1,067		20	107	107	427	2
3	Corner Guards	2002	876		20	88	88	350	3
4	Paint	2002	916		20	92	92	366	4
5	Valve Replacement	2002	1,130		20	113	113	414	5
6	Install Exit & Emerg. Lights	2002	860		20	172	172	616	6
7	Paint	2002	818		20	82	82	279	7
8	Decorating-Paint	2002	543		20	54	54	181	8
9	Paint	2002	2,143		20	107	107	330	9
10	Boiler Repair	2003	4,263		20	355	355	1,066	10
11	Heating Equip.	2003	501		20	25	25	73	11
12	Boiler Equip.	2003	500		20	25	25	73	12
13	Hot Water Heating Coils	2003	2,464		20	164	164	438	13
14	Fixed Broken Piping	2003	835		20	56	56	144	14
15	Air Condition Start Up	2003	1,919		20	96	96	248	15
16	Exhaust System For Oxygen	2003	2,150		20	215	215	520	16
17	Generator Maint.	2003	1,445		20	72	72	175	17
18	Awning Roto Gear Operator	2003	1,916		20	192	192	463	18
19	Garden Work	2003	998		20	100	100	241	19
20	Exterior Repairs	2003	1,541		20	154	154	360	20
21	Faucet And Back Splash	2003	934		20	47	47	109	21
22	Water Heater Repair	2003	1,112		20	56	56	120	22
23	Seco Refrigeration-Boiler Repairs	2004	802		20	160	160	321	23
24	Weather Temp	2004	939		20	94	94	188	24
25	Roof Repairs	2004	2,200		20	220	220	440	25
26	Screens	2004	800		20	80	80	160	26
27	Sprinkler	2004	1,512		20	151	151	302	27
28	Eltek Corp-Hvac	2004	1,265		20	253	253	506	28
29	Heating Coil	2004	2,055		20	206	206	377	29
30	Electrical Repairs	2004	766		20	77	77	134	30
31	Cement Work	2004	2,887		20	289	289	409	31
32	Eltek Corp-Ac Condensing Unit	2004	3,224		20	645	645	913	32
33	Generator	2004	601		20	120	120	170	33
34	TOTAL (lines 1 thru 33)		$ 3,276,900	$ 129,820		$ 166,097	$ 36,277	$ 1,049,190	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,276,900	$ 129,820		$ 166,097	$ 36,277	$ 1,049,190	1
2	Parking Signs	2004	555		20	56	56	69	2
3	Interior Remodel	2004	17,647		20	1,765	1,765	2,206	3
4	New Driveway	2004	4,960		20	496	496	620	4
5	Hvac Repair	2004	1,484		20	148	148	161	5
6	Roofing	2004	1,100		20	110	110	119	6
7	Warewasher Motor, Impeller	2004	1,289		20	129	129	140	7
8	Construction	2004	35,557		20	3,556	3,556	3,852	8
9	Cubicle Curtain	2004	1,288		20	258	258	322	9
10	Hvac - Saddle Valve	2004	628		20	31	31	34	10
11	Hvac - Motor, Fan Blade	2004	588		20	29	29	42	11
12	Repair Hot Water Line	2004	530		20	27	27	51	12
13	Conf Room/Ceiling	2005	31,000		20	1,292	1,292	1,292	13
14	Conf Room/Ceiling	2005	60,000		20	2,000	2,000	2,000	14
15	Conf Room/Ceiling	2005	47,035		20	1,568	1,568	1,568	15
16	Cold Patch	2005	5,683		20	47	47	47	16
17	Water Main Break	2005	30,670		20	256	256	256	17
18	Utility Room	2005	7,899		20	66	66	66	18
19	A/C Repair	2005	1,647		20	82	82	82	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,460	$ 129,820		$ 178,013	$ 48,193	$ 1,062,117	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	84		1995	1962	$ 2,932,035	$ 76,346	20	$ 146,602	$ 70,256	$ 921,867	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
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34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,932,035	$ 76,346		$ 146,602	$ 70,256	$ 921,867	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC		2002	2002	$ 8,885	$ 228	40	$ 228	$	$ 750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	7,340	367	20	367		1,284	9
10	Allocation - 2201 Main LLC			2003	8,650	432	20	432		1,081	10
11	Allocation - 2201 Main LLC			2005	430	10	20	10		10	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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25											25
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27											27
28											28
29											29
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31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 25,305	$ 1,037		$ 1,037	$	$ 3,125	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 256,584	$ 10,581	$ 34,045	$ 23,464	10	$ 193,424	71
72	Current Year Purchases	8,265	180	198	18	10	198	72
73	Fully Depreciated Assets	12,182				10	12,182	73
74								74
75	TOTALS	$ 277,031	$ 10,761	$ 34,243	$ 23,482		$ 205,804	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	1997	$ 47,208	$	$	$	5	$ 35,408	76
77		Care Centers Allocation	1900	12,380	907	907		5	9,375	77
78										78
79										79
80	TOTALS			$ 59,588	$ 907	$ 907	$		$ 44,783	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,954,513	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,488	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,675	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,312,704	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers				4,226			5
6								6
7	TOTAL				$ 4,226 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,142 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 84,969	$		$ 84,969	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,809			9,809	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			93,650			93,650	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				117,003		117,003	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						82,217		82,217	13
14	TOTAL			$		$ 188,428	$ 199,220		$ 387,648	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (19,387)	$ 66,302	1
2	Cash-Patient Deposits	21,862	21,862	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	715,013	887,813	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108,701	108,701	6
7	Other Prepaid Expenses	13,360	13,360	7
8	Accounts Receivable (owners or related parties)		121,839	8
9	Other(specify): See Attached Schedule	1,388,294	1,388,294	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,227,843	$ 2,608,171	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		115,041	13
14	Buildings, at Historical Cost		2,977,499	14
15	Leasehold Improvements, at Historical Cost	520,971	520,971	15
16	Equipment, at Historical Cost	311,800	481,773	16
17	Accumulated Depreciation (book methods)	(491,317)	(1,442,645)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	188	89,302	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 341,642	$ 2,741,941	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,569,485	$ 5,350,112	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 943,495	$ 1,116,296	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,585	19,585	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,073	71,073	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,805	3,805	31
32	Accrued Real Estate Taxes(Sch.IX-B)	172,767	172,767	32
33	Accrued Interest Payable		154,583	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	230,211		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,440,936	$ 1,538,109	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		435,000	39
40	Mortgage Payable		1,873,003	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,308,003	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,440,936	$ 3,846,112	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,128,549	$ 1,504,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,569,485	$ 5,350,112	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,591,548	1	
2	Restatements (describe):		2	
3	**Health Insurance Premium**	5,950	3	
4	**Depreciation**	(107,941)	4	
5	**Misc.**	1,692	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,491,249	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(362,700)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (362,700)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,128,549	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,888,112	1
2	Discounts and Allowances for all Levels	(931,284)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,956,828	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	843,674	6
7	Oxygen	4,560	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 848,234	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,183	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,768	19
20	Radiology and X-Ray	4,190	20
21	Other Medical Services	50,055	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 205,196	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	59,475	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,475	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,972	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,972	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,076,705	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	784,026	31
32	Health Care	1,650,167	32
33	General Administration	1,002,313	33
	B. Capital Expense		
34	Ownership	569,261	34
	C. Ancillary Expense		
35	Special Cost Centers	387,648	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,439,405	40
41	**Income before Income Taxes (line 30 minus line 40)****	(362,700)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (362,700)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,734	2,044	$ 67,022	$ 32.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,946	9,591	245,948	25.64	3
4	Licensed Practical Nurses	17,614	19,797	434,869	21.97	4
5	CNAs & Orderlies	50,429	53,657	529,116	9.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,561	6,252	105,324	16.85	8
9	Activity Director	1,903	2,135	29,716	13.92	9
10	Activity Assistants	6,734	7,245	62,663	8.65	10
11	Social Service Workers	3,588	4,164	66,733	16.03	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,336	37,164	15.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,264	15,501	145,671	9.40	15
16	Dishwashers					16
17	Maintenance Workers	2,047	2,363	39,489	16.71	17
18	Housekeepers	10,969	11,916	104,122	8.74	18
19	Laundry	6,158	6,850	76,726	11.20	19
20	Administrator	1,994	2,110	81,177	38.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,819	6,333	59,935	9.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,122	2,386	29,466	12.35	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	141,803	154,680	$ 2,115,141 *	$ 13.67	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	191	$ 8,895	01-03	35
36	Medical Director	Monthly	13,320	09-03	36
37	Medical Records Consultant	Monthly	4,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,260	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	784	11-03	44
45	Social Service Consultant	14	828	12-03	45
46	Other(specify)				46
47	CCI (See Attached)		12,472	various	47
48					48
49	TOTAL (lines 35 - 48)	221	$ 42,031		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	112	$ 5,839	10-03	50
51	Licensed Practical Nurses	337	11,167	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	449	$ 17,006		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Zaruba	Administrator		$ 81,177
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,177

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR & R	Accounting	$ 32,703
Care Centers,Inc.	Accounting	297
Care Centers,Inc.	Bookkeeping	17,136
Care Centers,Inc.	Home Office	70,560
Care Centers,Inc.	Ancillary Admin.	10,080
Care Centers,Inc.	Data Processing	3,024
ADP	Payroll	6,042
Achieve Healthcare A/R Software	Computer Services	10,458
ADP Clocks	Computer Services	2,545
E- Health Data Solutions	MDS Software	1,770
See Supplemetal Schedule		31,446
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 186,061

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,651
Unemployment Compensation Insurance	35,676
FICA Taxes	158,635
Employee Health Insurance	66,800
Employee Meals	4,818
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Payroll Taxes	5,794
Pension Expense	7,112
Other Employee Welfare	3,736
Holiday Expense	1,130
TOTAL (agree to Schedule V, line 22, col.8)	$ 338,352

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,887
Health Care Worker Background Check	4,154
(Indicate # of checks performed 112)	
Dues &Subscribtions	6,022
Licenses & Fees	2,125
Yellow Page Advertising	95
Alloc. XCEL Medical	(209)
Alloc. Care Centers	2,338
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(95)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,317

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	537
Alloc. from Care Centers	2,431
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,968

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tri-State Nursing & Rehab Ctr # 0041186 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $4,128**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,016** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **45,990**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,818** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.